

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Somerset

814

218

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

268

Village or City

Deer's Island

(No.)

133

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lillie May Austin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov

7

1900

(Month)

(Day)

(Year)

7 AGE

14 yrs.

1 mos.

27 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Somerset Co.

PARENTS

10 NAME OF FATHER

Wesley Austin

11 BIRTHPLACE OF FATHER (State or country)

Somerset Co

12 MAIDEN NAME OF MOTHER

Lillie Webster

13 BIRTHPLACE OF MOTHER (State or country)

Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lillie Austin

(Address)

Deer's Island Md.

15

Filed

Jan 4

1914

G. H. Storrer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 31

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Dec 15

1914

to Jan 25

1914

that I last saw her alive on

Jan 25

1914

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

9 (Duration) 3 yrs. 3 mos. 1 ds.

Contributory Secondary Diphtheria

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. G. Alexander, M. D.

Jan 4, 1914 (Address) Deer's Island

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Deer's Island Md

Jan 4, 1914

20 UNDERTAKER

ADDRESS

J. G. Storrer

Deer's Island Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

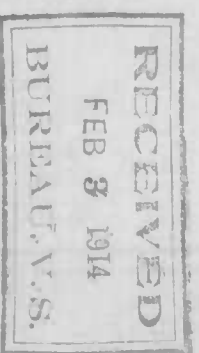
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH**  
 County Somerset 815  
 Village or City Westover (No. 91) St.        Ward         
**2 FULL NAME** Loetie May Benston (Benston)

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 264

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b> <u>female</u>	<b>4 COLOR OR RACE</b> <u>colored</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>Single</u>
<b>6 DATE OF BIRTH</b> <u>Dec. 30th. 1913</u> (Month) (Day) (Year)		
<b>7 AGE</b> <u>19</u> yrs. <u>13</u> mos. <u>13</u> ds.		If LESS than 1 day, <u>      </u> hrs. <u>      </u> min. ?
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>      </u>		
<b>9 BIRTHPLACE</b> (State or country) <u>Somerset Co</u>		
<b>PARENTS</b>	<b>10 NAME OF FATHER</b> <u>Joshua Benston</u>	
	<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Somerset Co.</u>	
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Leana Wallops</u>	
	<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Somerset Co</u>	

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Joshua Benston  
 (Address) Westover Md.

 15 Filed Jan 18th 1914 G. E. Dickinson  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Jan 18, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
      , 191      , to       , 191      .

 that I last saw him        alive on       , 191      .

 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Probably Broncho pneumonia
I did not see the case

 (Duration)        yrs. one mos.        ds.

 Contributory  
 Secondary

 (Duration)        yrs.        mos.        ds.

 (Signed) G. W. Gill, M. D.

Jan 18, 1914. (Address) Manassas Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

 At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

 Where was disease contracted, If not at place of death?       

 Former or usual residence       

<b>19 PLACE OF BURIAL OR REMOVAL</b> <u>Westover</u>	<b>DATE OF BURIAL</b> <u>Jan 19, 1914</u>
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<b>20 UNDERTAKER</b> <u>Herbert Wilson</u>	<b>ADDRESS</b> <u>Waller's Building</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

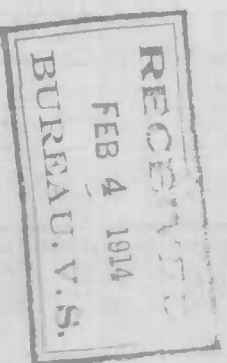
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*—such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 816  
 County Somerset  
 Village or City Princes Anne (No. 1246) St.        Ward         
**2 FULL NAME** Hester Birchhead  
 Registration Dist. No. 266  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female  
**4 COLOR OR RACE** Colored  
**5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** (Write the word) Married  
**6 DATE OF BIRTH** Sept 14, 1884  
 (Month) (Day) (Year)  
**7 AGE** 49 yrs. 5 mos. 16 ds. If LESS than 1 day,        hrs. OR        min. ?  
**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)         
**9 BIRTHPLACE** (State or country) Maryland  
**PARENTS**  
**10 NAME OF FATHER** Robert Anderson  
**11 BIRTHPLACE OF FATHER** (State or country) Maryland  
**12 MAIDEN NAME OF MOTHER** Melvinia Williams  
**13 BIRTHPLACE OF MOTHER** (State or country) Maryland  
**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) John Birchhead  
 (Address) Princes Anne  
**15** Filed 1 31, 1914 A. G. Smith  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** January 30, 1914  
 (Month) (Day) (Year)  
**17 I HEREBY CERTIFY, That I attended deceased from** Jan 5, 1914, to Jan 30, 1914,  
 that I last saw her alive on Jan 28, 1914,  
 and that death occurred on the date stated above, at 10.45 P. M.  
 The CAUSE OF DEATH\* was as follows:  
Double emphysema of  
Atrium of Right Ventricle  
 (Duration) 1 yrs.        mos.        ds.  
 Contributory         
 Secondary         
 (Signed) Henry M. Lambford, M. D.  
Jan 31, 1914. (Address) Princes Anne  
 \*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**  
 At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.  
 Where was disease contracted, If not at place of death?         
 Former or usual residence         
**19 PLACE OF BURIAL OR REMOVAL**        **DATE OF BURIAL** 7/1, 1914  
**20 UNDERTAKER**        **ADDRESS**

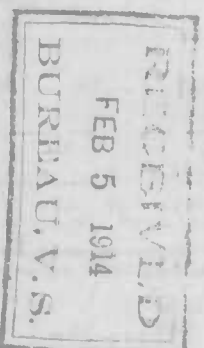
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

817

County

Somerset

Village or City

Marion

(No.

St.;

Ward)

## 2 FULL NAME

Thos. Franklin Bradshaw

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

261

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the words)

Infant

## 6 DATE OF BIRTH

12 - 5 - 1914

(Month)

(Day)

(Year)

## 7 AGE

1 yrs. 12 mos. 12 ds.

If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md

## 10 NAME OF FATHER

H K Bradshaw

## PARENTS

## 11 BIRTHPLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Florence Judd

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H K Bradshaw

(Address)

Kingston

## 15

Filed

1/18, 1914 J. J. Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 - 17, 1914

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Whooping cough  
found dead in bed

No Dr. in attendance (Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. J. Adams L. M. D.

1/18, 1914 (Address)

Marion

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Pauls Cemetery

1 - 19, 1914

## 20 UNDERTAKER

## ADDRESS

W. O. Dixon

Marion

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

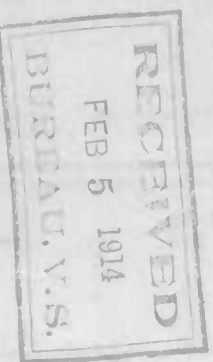
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic vesicular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, CRIMINAL, or NONCRIMINAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Somerset

818

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

266

Village or City

Tylerton

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Bruce

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

Jan. 30, 1914

(Month)

(Day)

(Year)

7 AGE

If LESS than 1 day, hrs. 30 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Tylerton, Ind.

10 NAME OF FATHER

John F. Bruce

11 BIRTHPLACE OF FATHER (State or country)

New York City

12 MAIDEN NAME OF MOTHER

Fina Marshall

13 BIRTHPLACE OF MOTHER (State or country)

Tylerton

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

John F. Bruce

(Address)

Tylerton

15

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 30, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from 2 P.M.

Jan. 30, 1914, to Jan. 30, 1914

that I last saw him alive on Jan. 30, 1914

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Asphyxia neonatorum

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Charles J. Schwartz

M. D.

Jan. 31, 1914 (Address) Ewell

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tylerton

Jan. 30, 1914

20 UNDERTAKER

ADDRESS

C. B. Bradshaw

Ewell

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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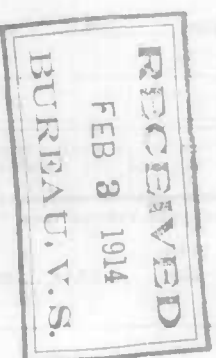
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1 PLACE OF DEATH 820  
 County Somerset  
 Village or City Upper Fairmount (No. 45) St; Mayland Ward)  
 2 FULL NAME Hester Jane Galtin  
 Registration Dist. No. 264  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
 (Write the word)  
 6 DATE OF BIRTH 18 33 May 25 X  
 (Month) (Day) (Year)  
 7 AGE 81 9 months If LESS than 1 day, .... hrs.  
 yrs. .... mos. .... ds. OR .... min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work house work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Worcester County

10 NAME OF FATHER Peter Townsend  
 11 BIRTHPLACE OF FATHER (State or country) Worcester County  
 12 MAIDEN NAME OF MOTHER Maryann Galtin  
 13 BIRTHPLACE OF MOTHER (State or country) Worcester County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Mervin Beull  
 (Address) Upper Fairmount

15 Filed Jan 26 1914 H. E. Dickinson  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 to Dec 10, 1914.

that I last saw him alive on Dec 10, 1914.

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Cancer of the Throat

(Duration) 3 yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) E. S. Miles, M. D.

Jan 24, 1914 (Address) Upper Fairmount

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. James Church Jan 24, 1914

20 UNDERTAKER ADDRESS 26

James M. ...

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 4 1914  
BURBANK, V. S.

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1 PLACE OF DEATH 821  
 County Anne Arundel  
 Village or City Manai (No. 189) St.; Ward)  
 Registration Dist. No. 261  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
 2 FULL NAME Felver Collins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
 (Write the word)

6 DATE OF BIRTH 7 - 5 - 1913  
 (Month) (Day) (Year)

7 AGE 6 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

PARENTS  
 10 NAME OF FATHER Geor Collins  
 11 BIRTHPLACE OF FATHER (State or country) md  
 12 MAIDEN NAME OF MOTHER Martha Jackson  
 13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Geo Collins

(Address) Manai

15 Filed 1/30, 1914 J. J. Adams  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 - 29 - 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
 \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ slive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the dste stated above, at \_\_\_\_\_m.

The CAUSE OF DEATH was as follows:

No Dr. for some time  
child always sickly  
 (Duration) \_\_\_\_\_yrs. \_\_\_\_\_mos. \_\_\_\_\_ds.

Contributory  
 Secondary

(Duration) \_\_\_\_\_yrs. \_\_\_\_\_mos. \_\_\_\_\_ds.  
 (Signed) J. J. Adams M.D.  
1/30, 1914 (Address) Manai

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
 If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Francis DATE OF BURIAL 1 - 30 - 1914

20 UNDERTAKER Adams ADDRESS Manai

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

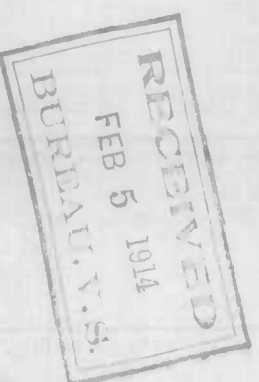
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## 1 PLACE OF DEATH

822

County SomersetVillage or City Cornfield (No. \_\_\_\_\_)

Registration Dist. No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Wm. James Cullen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan 20, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Cornfield Somerset Co

PARENTS  
10 NAME OF FATHER Wm. J. Cullen  
11 BIRTHPLACE OF FATHER (State or country) Cornfield Md  
12 MAIDEN NAME OF MOTHER Clara J. Redmond  
13 BIRTHPLACE OF MOTHER (State or country) Cornfield Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Howell(Address) Cornfield Md

15 Jan 20, 1914  
Filed E. E. Hollins

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Still Born

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) W. F. Howell, M. D.  
Jan 20, 1914 (Address) Cornfield

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mariners Cemetery DATE OF BURIAL Jan 20, 1914

20 UNDERTAKER R. J. Adams ADDRESS Cornfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

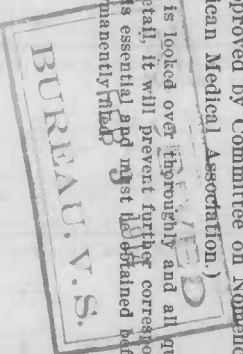
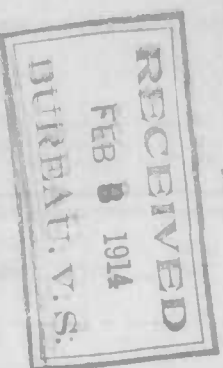
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Summit 823  
Village or City McDonna (No. 10) St.        Ward         
2 FULL NAME Ann Jael

STATE OF MARYLAND  
CERTIFICATE OF DEATH.  
Registration Dist. No. 263

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Do not know  
(Month) (Day) (Year)

7 AGE About 80 yrs. .... mos. .... ds. OR LESS than 1 day, .... hrs. .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)       

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Sampson Jael

11 BIRTHPLACE OF FATHER (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (State or country) Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myself  
Address Princess Anne Ind

15 Filed Jan 28 1914  
Enthart local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1914 to Jan 27, 1914, that I last saw her alive on Jan 27, 1914

and that death occurred on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH was as follows:

In Grippe

(Duration) .... yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.  
(Signed) H. A. Barnes M. D.  
Jan 28, 1914 (Address) Princess Anne

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL McDonna Ind DATE OF BURIAL Jan 29, 1914

20 UNDERTAKER Dashell Bros ADDRESS Princess Anne Ind

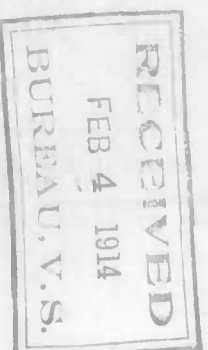
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		824	STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Somerset</u>		Registration Dist. No. <u>261</u>		
Village or City <u>Marion</u> (No. _____)		St.; _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Baby Gale</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Cue</u>	5 SINGLE, <u>Male</u> <u>Single</u> MARRIED, WIDOWED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>Stue Born Jan 31, 1914</u> (Month) (Day) (Year)				
7 AGE _____ yrs. _____ mos. _____ ds.		1 day, _____ hrs. <u>OR</u> _____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Somerset Co</u>				
PARENTS	10 NAME OF FATHER <u>Charles Gale</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Somerset Co</u>			
	12 MAIDEN NAME OF MOTHER <u>Adah's Hughes</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Somerset Co</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles Gale</u> (Address) <u>Marion</u>				
15 Filed <u>1/31</u> , 191 <u>4</u> <u>J. J. Adams</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Stue Born Jan 31, 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m., The CAUSE OF DEATH* was as follows: <u>Stue Born</u> (Duration) _____ yrs. _____ mos. _____ ds.				
Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>George Clutter</u> , M. D. <u>Jan 31, 1914</u> (Address) <u>Marion</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Ebaneser</u>			DATE OF BURIAL <u>1-31</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Acordigan</u>			ADDRESS <u>Marion</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

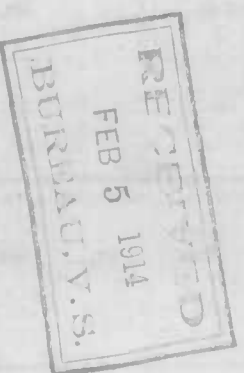
[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Pneumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for violent surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <i>Deal Island</i>		825		STATE OF MARYLAND	
County <i>Somerset md</i>		92		CERTIFICATE OF DEATH	
Village or City <i>Deal Island</i> (No. <i>135</i> )		St.:		Registration Dist. No. <i>268</i>	
2 FULL NAME <i>Gracie Louise Graham</i>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>married</i> (Write the word)			
6 DATE OF BIRTH <i>March 20, 1850</i> (Month) (Day) (Year)					
7 AGE <i>64</i> yrs. <i>10</i> mos. <i>7</i> ds. OR <i>1</i> day, <i>hrs.</i> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>House wife</i> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <i>Deal Island md</i>					
PARENTS	10 NAME OF FATHER <i>Wallace Webster</i>				
	11 BIRTHPLACE OF FATHER (State or country) <i>md</i>				
	12 MAIDEN NAME OF MOTHER <i>Eliza Rowe</i>				
	13 BIRTHPLACE OF MOTHER (State or country) <i>md</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>John E. Graham</i> (Address) <i>Deal Island md</i>					
15 Filed <i>Jan 14</i> 1914 <i>Geo. B. Stoner</i> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>January 11th, 1914</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>January 7th</i> 1914, to <i>January 10th</i> 1914, that I last saw him alive on <i>January 10th</i> 1914, and that death occurred on the date stated above, at <i>2 p. m.</i> , The CAUSE OF DEATH* was as follows: <i>Labor Pneumonia</i> (Duration) <i>4</i> yrs. <i>4</i> mos. <i>4</i> ds. Contributory <i>Chronic</i> Secondary (Duration) <i>4</i> yrs. <i>4</i> mos. <i>4</i> ds. (Signed) <i>W. E. Alexander</i> , M. D. <i>Jan 14, 1914</i> (Address) <i>Deal Island</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>1</i> yrs. <i>10</i> mos. <i>7</i> ds. In the State <i>1</i> yrs. <i>10</i> mos. <i>7</i> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <i>Deal Island Md</i> DATE OF BURIAL <i>Jan 15, 1914</i>					
20 UNDERTAKER <i>Geo. B. Stoner</i> ADDRESS <i>Deal Island Md</i>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

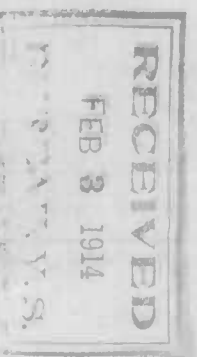
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection used not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH  
County Southern

Village or City Wt Vernon (No. 826)

<sup>2</sup> FULL NAME Infant

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 263

St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE Colored <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

<sup>6</sup> DATE OF BIRTH Jan 19, 1914  
(Month) (Day) (Year)

<sup>7</sup> AGE Still born If LESS than 1 day, hrs. OR min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE (State or country) Southern Co.

<sup>10</sup> NAME OF FATHER Sam Handy

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Southern Co.

<sup>12</sup> MAIDEN NAME OF MOTHER Frances Hall

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Southern Co.

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Benjamin Buckley  
(Address) Quincey Lane S.W.

<sup>15</sup> Filed Jan 20 1914  
Edmund Lind REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Jan 19, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Jan 19, 1914 to Jan 19, 1914

that I last saw h. alive on Jan 19, 1914

and that death occurred on the date stated above, at Southern

The CAUSE OF DEATH\* was as follows:  
Still born - before term

(Duration) yrs. mos. ds.

Contributory (Secondary)  
(Duration) yrs. mos. ds.

(Signed) W. A. Barman M. D.  
Jan 19, 1914 (Address) Crescent

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Wt Vernon DATE OF BURIAL Jan 20, 1914

<sup>20</sup> UNDERTAKER W. A. Barman ADDRESS W. A. Barman

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

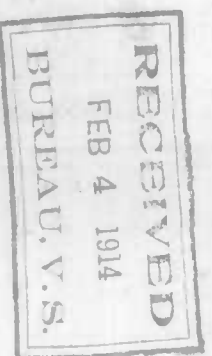
[Approved by L. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PLACE OF DEATH

County

Village or City

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>Black</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>August 24</i> , 1898 (Month) (Day) (Year)		
7 AGE <i>15</i> yrs. <i>4</i> mos. <i>13</i> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <i>Somerset</i>		

PARENTS	10 NAME OF FATHER <i>Isaac Hayward</i>
	11 BIRTHPLACE OF FATHER (State or country) <i>Somerset</i>
	12 MAIDEN NAME OF MOTHER <i>Millie Hayward</i>
	13 BIRTHPLACE OF MOTHER (State or country) <i>Somerset</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 FILED *Jan 10*, 1914 *E. E. Collins*  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *January 7*, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from *Dec 25*, 1913, to *Jan 7*, 1914, that I last saw him alive on *Jan 3*, 1914, and that death occurred on the date stated above, at *9 P.* m. The CAUSE OF DEATH\* was as follows:

*Typhoid* (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. *15* ds.  
Contributory (Secondary)  
*Pneumonia* (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. *2* ds.

(Signed) *G. J. Simpson*, M. D.  
*Jan 8*, 1914 (Address) *Leisfield Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Asbury Colored Cemetery* *Jan. 11<sup>th</sup>*, 1914  
20 UNDERTAKER *J. S. Lawson* ADDRESS *Leisfield*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

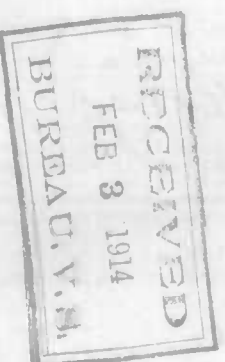
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Somerset</u> 828			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Fylerton</u> (No. <u>120</u> )			Registration Dist. No. <u>266</u>		
2 FULL NAME <u>Alice H. Hoffman</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>N.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	16 DATE OF DEATH <u>Jan. 24</u> , 191 <u>4</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>unknown</u> , 18 <u>88</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 21</u> , 191 <u>4</u> , to <u>Jan. 23</u> , 191 <u>4</u> that I last saw her alive on <u>Jan. 23</u> , 191 <u>4</u>		
7 AGE <u>56</u> yrs. <u></u> mos. <u></u> ds.			and that death occurred on the date stated above, at <u>3 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Chronic Nephritis</u> (Duration) <u></u> yrs. <u></u> mos. <u></u> ds.		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment to which employed (or employer)			Contributory (Secondary) <u>Uremia</u> (Duration) <u></u> yrs. <u></u> mos. <u>2</u> ds.		
9 BIRTHPLACE (State or country) <u>Fylerton, Md.</u>			(Signed) <u>Charles J. Schwartz</u> , M. D. <u>Jan. 31</u> , 191 <u>4</u> (Address) <u>Fylerton</u>		
PARENTS	10 NAME OF FATHER <u>Abraham Evans</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	11 BIRTHPLACE OF FATHER (State or country) <u>Fylerton, Md.</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u></u> yrs. <u></u> mos. <u></u> ds. In the State <u></u> yrs. <u></u> mos. <u></u> ds. Where was disease contracted, If not at place of death?			
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Evans</u>	Former or usual residence			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Fylerton, Md.</u>	19 PLACE OF BURIAL OR REMOVAL <u>Fylerton</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>Alice H. Hoffman</u> (Address) <u>Fylerton</u>			20 UNDERTAKER <u>A. B. Bradshaw</u>		
15 Filed <u></u> , 191 <u>4</u>			DATE OF BURIAL <u>Jan. 25</u> , 191 <u>4</u> ADDRESS <u>Swell</u>		
REGISTRAR					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Somerset</u> 829		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Marion</u> (No. <u>604</u> )		Registration Dist. No. <u>261</u>	
2 FULL NAME <u>Samuel H. Horry</u>		[It death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>	
6 DATE OF BIRTH <u>Don't know</u> , 18 <u>34</u> (Month) (Day) (Year)			
7 AGE <u>80</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds. <u>OR</u> <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farmer</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Levin Horry</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Don't know</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Cornelius Horry</u> (Address) <u>Marion Md</u>			
15 Filed <u>1-28</u> , 191 <u>4</u> <u>J. J. Adams</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>1</u> <u>28</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 24</u> , 191 <u>4</u> , to <u>Jan 28</u> , 191 <u>4</u> , that I last saw h. in <u>alive</u> on <u>1-27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Paralysis &amp; C. Laverton</u>			
(Duration) <u>4</u> yrs. <u>0</u> mos. <u>0</u> ds.			
Contributory <u>age</u> Secondary			
(Duration) <u>4</u> yrs. <u>0</u> mos. <u>0</u> ds.			
(Signed) <u>L. S. Allen</u> , M. D. <u>1-28</u> , 191 <u>4</u> (Address) <u>Marion Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, it not at place of death? Former or usual residence <u>Library</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Library</u>		DATE OF BURIAL <u>1-30</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Edw. Dilon</u>		ADDRESS <u>Marion</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

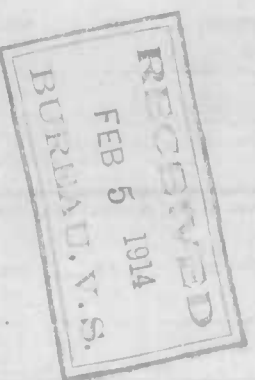
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbohc acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Sumner Co</u> 830		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Marion</u> (No. <u>64</u> )		Registration Dist. No. <u>261</u>	
2 FULL NAME <u>Sarah J. J. J. J.</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>Not known</u> (Month) (Day) (Year)			
7 AGE <u>About 59</u> yrs. mos. ds.		It LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Md</u>			
PARENTS	10 NAME OF FATHER <u>Don't know</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>"</u>		
	12 MAIDEN NAME OF MOTHER <u>Anne J. Handy</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Noah Roach</u> (Address) <u>Marion</u>			
15 Filed <u>1/23</u> 191 <u>4</u> <u>J. J. J. J.</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 22</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY That I attended deceased from <u>Callus &amp; J. J. J. J.</u> 191 <u>4</u> that I last saw him <u>when he died</u> alive on <u>Jan 22</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>5 A</u> m. The CAUSE OF DEATH* was as follows: <u>Cerebral Exhaustion</u>			
Contributors (Duration) yrs. mos. ds. Primary <u>Cerebral Exhaustion</u> Secondary <u>"</u> (Signed) <u>George A. Coulburn</u> , M. D. <u>Jan 22</u> , 191 <u>4</u> (Address) <u>Marion</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Mt. Air County</u>		DATE OF BURIAL <u>1-24</u> , 191 <u>4</u>	
20 UNDERTAKER <u>A. W. Dixon</u>		ADDRESS <u>Marion</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

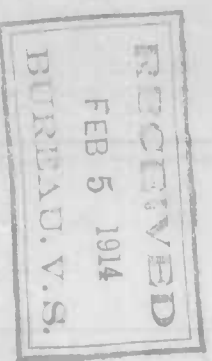
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Village or City

(No.

St.; Ward)

## 2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

Jan 19th, 1914

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

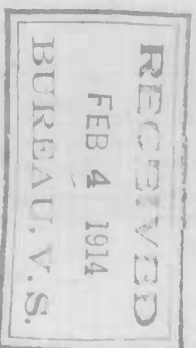
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Somerset</u>		832	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Dames Quarter</u> No. _____		Registration Dist. No. <u>267</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Georgia R. Jones</u>		St.; Ward _____		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>F</u>	4 COLOR OR RACE <u>B.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>Feb. 27, 1912</u> (Month) (Day) (Year)				
7 AGE <u>1</u> yrs. <u>10</u> mos. <u>5</u> ds. <u>OR</u> min. ? If LESS than 1 day, ____ hrs.				
8 OCCUPATION (a) Trade, profession, or particular kind of work. _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Md.</u>				
PARENTS	10 NAME OF FATHER <u>William C. Jones</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			
	12 MAIDEN NAME OF MOTHER <u>Lena Halland</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William C. Jones</u> (Address) <u>Dames Quarter, Md.</u>				
15 <u>Jan. 4, 1914</u> <u>W. S. Kelly</u> Filed REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Jan. 2, 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 2, 1914</u> , to <u>Jan. 2, 1914</u> , that I last saw her alive on <u>Jan. 2, 1914</u> , and that death occurred on the date stated above, at _____ m.				
The CAUSE OF DEATH* was as follows: <u>Bronchial Pneumonia</u> (Duration) ____ yrs. ____ mos. <u>5</u> ds. Contributory <u>Toxaemia</u> Secondary (Signed) <u>E. P. Simpson</u> , M. D. <u>MAR 19 1914</u> (Address) <u>CHANGE MD</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Dames Quarter, Md.</u>				DATE OF BURIAL <u>Jan 4, 1914</u>
20 UNDERTAKER <u>T. W. Hendry</u>				ADDRESS <u>Deals Island Md.</u>
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED  
FEB 7 1914  
BUREAU. V. S.

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAR 21 1914  
BUREAU. V. S.

Sent for copy on  
correspondence.

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833

## 1 PLACE OF DEATH

County

Somerset

Village or City

Brisfield

(No.

St.;

Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

Jan 23, 1914  
(Month) (Day) (Year)

7 AGE

It LESS than  
1 day.....hrs.  
OR.....min. ?

yrs. mos. 1 ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Brisfield, Md.

10 NAME OF FATHER

Edward B Jones

11 BIRTHPLACE OF FATHER

(State or country)

Somerset Co

12 MAIDEN NAME OF MOTHER

Maggie Harris

13 BIRTHPLACE OF MOTHER

(State or country)

Brisfield

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Jones

(Address)

Brisfield

15

Filed

Jan 25, 1914 B. E. Ballins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 25, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191....., to 191.....

that I last saw him..... alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

Had no Physician

(Duration)..... yrs. mos. ds.

Contributory  
Secondary

(Duration)..... yrs. mos. ds.

(Signed)

B. E. Ballins, M. D.

Jan 25, 1914 (Address) Brisfield

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fisherman Cemetery

Jan 25, 1914

20 UNDERTAKER

ADDRESS

R. J. Williams

Brisfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

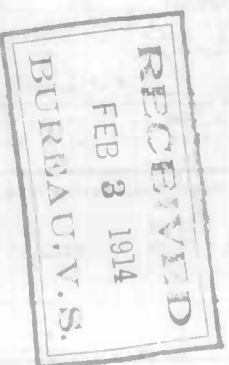
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

834

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268Village or City Brown Ann (No. 9)St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Wm. J. Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 2, 1914  
(Month) (Day) (Year)

7 AGE 7 yrs. 7 mos. 7 ds. If LESS than 1 day, 7 hrs. OR 7 min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Wm. J. Jones

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Bess Walston

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. J. Jones

(Address) J. Jones & Sons, Inc.

15 Filed Jan 9th, 1914 J. J. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at 1914 m.

The CAUSE OF DEATH\* was as follows:

No. 1: in all cases, was in  
the last 3 or 4 days of  
life, cause of death was  
Paralysis of (Duration) 8 yrs. 8 mos. 8 ds.

Contributory Bronchitis  
Secondary

(Duration) 8 yrs. 8 mos. 8 ds.

(Signed) J. J. Smith M. D.

1/9, 1914. (Address) B. Jones

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 8 yrs. 8 mos. 8 ds. In the State 8 yrs. 8 mos. 8 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenwood

DATE OF BURIAL 1/10, 1914

20 UNDERTAKER Wm. Jones

ADDRESS B. Jones

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

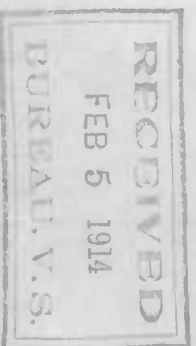
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

835

County SummitVillage or City Rehoboth (No. 105)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 262

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME H. James Long

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED —  
(Write the word)

6 DATE OF BIRTH Mar. 11<sup>th</sup>, 1910  
(Month) (Day) (Year)

7 AGE 5 yrs. 9 mos. 27 ds. If LESS than 1 day, hrs. ? OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work ✓  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Harry C. Long

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie S. Powell

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry C. Long  
(Address) Rte. 1, Pocomoke City

15 Filed Jan 30, 1914 C A Powell  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 6<sup>th</sup>, 1914 to Jan 8<sup>th</sup>, 1914  
that I last saw him alive on Jan 8<sup>th</sup>, 1914

and that death occurred on the date stated above, at 11 A. m.  
The CAUSE OF DEATH\* was as follows:

Cephalitis

(Duration) yrs. mos. 2 ds.  
Contributory (Secondary) Acute Indigestion

(Signed) J. M. Wilson, M. D.  
Jan 8<sup>th</sup>, 1914 (Address) Pocomoke City

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rehoboth DATE OF BURIAL Jan 9, 1914

20 UNDERTAKER Stenson Bros ADDRESS Pocomoke

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

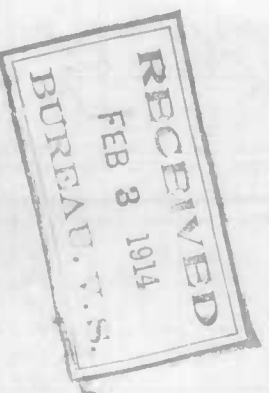
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH *836*  
County *Somerset*  
Village or City *Crisfield* (No. *28*) St.; Ward  
2 FULL NAME *W. Henry Nelson*  
Registration Dist. No. *265*  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*  
6 DATE OF BIRTH *Sept. 26<sup>th</sup>, 1890*  
(Month) (Day) (Year)  
7 AGE *23* yrs. *3* mos. *13* ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Walterman*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Working with his father in Optical Business*

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *Jas. H. Nelson*

11 BIRTHPLACE OF FATHER (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Josephine Lawson*

13 BIRTHPLACE OF MOTHER (State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Josephine Nelson*

(Address) *Crisfield, Md.*

15 *Jan 11, 1914* *E. E. Collins*  
Filed REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *265*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan. 8<sup>th</sup>, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from *Jan 6, 1914, to Jan 8, 1914.*

that I last saw him alive on *Jan 8, 1914*

and that death occurred on the date stated above, at *10 A. m.*

THE CAUSE OF DEATH was as follows:

*Cardiac Dilatation  
Pulmonary Phthisis*

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) *Mrs. H. H. H. H. H.*, M. D.

*Jan 8, 1914* (Address) *Crisfield Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

*Asbury Cemetery* DATE OF BURIAL *Jan. 13<sup>th</sup>, 1914*

20 UNDERTAKER *J. L. Lawson* ADDRESS *Crisfield, Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

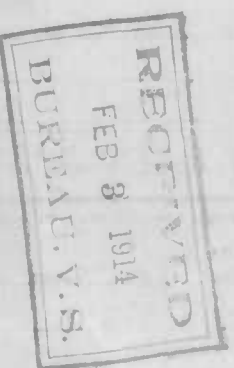
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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>Deals Island</u>		837		STATE OF MARYLAND	
County <u>Worcester</u>				CERTIFICATE OF DEATH	
Village or City <u>Deals Island</u>		(No. <u>136</u> )		Registration Dist. No. <u>268</u>	
2 FULL NAME <u>William Parkinson</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Aug 7</u> , 191 <u>3</u> (Month) (Day) (Year)					
7 AGE <u>9</u> yrs. <u>9</u> mos. <u>0</u> ds.		If LESS than 1 day, <u>0</u> hrs. <u>0</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Sammy Parkinson</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Mamie White</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mamie Parkinson</u> (Address) <u>Worcester Md.</u>					
15 Filed <u>Jan 20</u> , 191 <u>4</u> <u>Geo B. Warner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 20</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 16</u> , 191 <u>4</u> , to <u>Jan 19</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Bacterial Enteritis</u>					
(Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Contributory <u>Emaciation &amp; Exhaustion</u> Secondary					
(Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>E. P. Simpson</u> , M. D. <u>Jan 20</u> , 191 <u>4</u> . (Address) <u>Charmes Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted? If not at place of death? Former or usual residence <u>—</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Deals Island Md.</u>				DATE OF BURIAL <u>Jan 20</u> , 191 <u>4</u>	
20 UNDERTAKER <u>L. D. Hardy</u>				ADDRESS <u>Deals Island Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

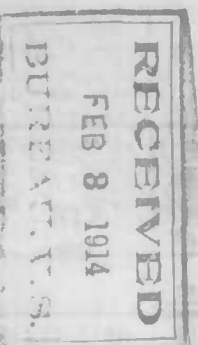
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic adicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

Village or City Crisfield (No. Jersey St.; Ward)

2 FULL NAME Robert Paterson

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 27, 1897  
(Month) (Day) (Year)

7 AGE 36 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Oyster opener  
(b) General nature of industry, business, or establishment in which employed (or employer) Oyster packing

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Frank Paterson

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Frankie Brinkley

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beckel Marshall

(Address) Crisfield Md.

15 Filed Jan 13, 1914 E. E. Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 10, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Jan. 10, 1914, to Jan. 10, 1914.

that I last saw him alive on Jan. 10, 1914

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Acute indigestion  
The patient came down with severe  
vomiting and diarrhea.  
MR. (Duration) 1/2 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) W. J. Barkley, M. D.  
Jan. 11, 1914. (Address) 309 W. md. ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lawsonia DATE OF BURIAL Feb 13, 1914

20 UNDERTAKER R. J. Adams ADDRESS Crisfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

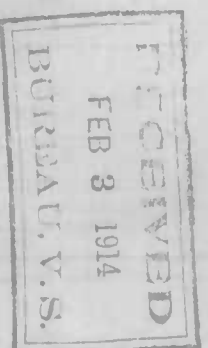
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Somerset*

Village or City

*Westover*

(No.

St. Ward)

Registration Dist. No. *262*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Robert H. Powell*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*5 SINGLE, MARRIED, WIDDED, OR DIVORCED  
(Write the word)*married*

6 DATE OF BIRTH

*Nov**8**1834*

(Month)

(Day)

(Year)

7 AGE

*79**1**mos.**36**ds.*

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Carpenter & Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Worcester Co*

PARENTS

10 NAME OF FATHER

*David Henry Powell*

11 BIRTHPLACE OF FATHER

(State or country)

*Somerset Co*

12 MAIDEN NAME OF MOTHER

*Ann Maria Taylor*

13 BIRTHPLACE OF MOTHER

(State or country)

*Somerset Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Henry J. Powell*

(Address)

*Westover, Md*

15

Filed

*Jan 30, 1914**C. A. Powell*

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan**4**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*Dec 20, 1913**to**Dec 20, 1913*that I last saw him alive on *Dec 20, 1913*and that death occurred on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Exhaustion & Heart Failure*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary*old age*

(Duration)

yrs.

mos.

ds.

(Signed)

*1/5**1914*

(Address)

*Monrovia, Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Relleboth**Jan 5, 1914*

20 UNDERTAKER

ADDRESS

*Stenson Bros. Potomac*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED  
FEB 8 1914  
BUREAU, V. S.

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1 PLACE OF DEATH County <u>Somerset Co</u>		840	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Marion</u>		(No. <u>80</u> )	Registration Dist. No. <u>Key</u>	
2 FULL NAME <u>Louise H. Price</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>		
6 DATE OF BIRTH <u>Don't Know</u> 840				
7 AGE <u>73</u> yrs. <u>Don't Know</u> 1 day, <u>1</u> hrs. If LESS than 1 day, <u>1</u> min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmers</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>				
9 BIRTHPLACE (State or country) <u>Somerset Co</u>				
PARENTS	10 NAME OF FATHER <u>Robert Price</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary A. Riggins</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Price</u> (Address) <u>Marion Md</u>				
15 Filed <u>1/13</u> 191 <u>4</u> <u>F. J. Adams</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>1</u> <u>12</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 11</u> 191 <u>4</u> to <u>Jan 12</u> 191 <u>4</u> , that I last saw him alive on <u>Jan 11</u> 191 <u>4</u> , and that death occurred on the date stated above, at <u>12 noon</u> m.				
The CAUSE OF DEATH* was as follows: <u>Angina Pectoris</u>				
3 days (Duration) yrs. mos. ds.				
Contributory Secondary <u>Age</u>				
(Signed) <u>S. B. Allen</u> , M. D. 1-13, 191 <u>4</u> (Address) <u>Marion Md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Rehoboth</u>			DATE OF BURIAL <u>1-14</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Jacob Stinson</u>			ADDRESS <u>Rehoboth</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED  
FEB 5 1914  
BUREAU, U. S.

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## 1 PLACE OF DEATH

County

*Somerset*

841

478

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *261*

Village or City

*Marion*(No. *1*)St. *1*

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Emelia Scerfield*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

*married*

6 DATE OF BIRTH

*January*

(Month)

(Day)

*1861*  
(Year)

7 AGE

*53*

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Somerset Co Md*

PARENTS

10 NAME OF FATHER

*Nathan Turpin*

11 BIRTHPLACE OF FATHER

(State or country)

*Somerset Co Md*

12 MAIDEN NAME OF MOTHER

*Hennie — not known*

13 BIRTHPLACE OF MOTHER

(State or country)

*Somerset Co Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Emelia Scerfield*

(Address)

*Marion Md*

15

Filed

*1/20*

191

*J. J. Adams*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 18*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*Spt 1*

191

2

to

*Jan 18*

191

4

that I last saw him alive on

*Jan 10*

191

4

and that death occurred on the date stated above, at *11 A. m.*

The CAUSE OF DEATH\* was as follows:

*Cordis Thrombosis  
suppurative pneumonia*

(Duration)

yrs.

mos.

7

ds.

Contributory  
Secondary*Pneumonia*

(Duration)

yrs.

mos.

2

ds.

(Signed)

*George C. Culver*

M. D.

*Jan 19*

191

4

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt Zion Cemetery**1-20*, 191

4

20 UNDERTAKER

ADDRESS

*W. D. Dixon**Marion*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

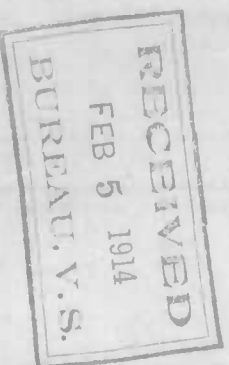
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, *q. e.*, *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For YOUNG DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 842  
County Somerset

Village or City Crisfield (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Sarah F. Somers

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 265

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Apr 22, 1840  
(Month) (Day) (Year)

7 AGE 73 yrs. 9 mos. 8 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Somerset Co. Md

10 NAME OF FATHER Jessie Somers

11 BIRTHPLACE OF FATHER (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Jane Adams

13 BIRTHPLACE OF MOTHER (State or country) Somerset Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Prattman Somers

(Address) Crisfield Md

15 Filed Jan 31, 1914 E. C. Hollins  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1914, to Jan 30, 1914.  
that I last saw her alive on Jan 30, 1914.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Lagrippe  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. F. Hall, M. D.

Jan 30, 1914 (Address) Crisfield Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Pauls Cemetery Feb 1, 1914

20 UNDERTAKER ADDRESS

R. J. Adams Crisfield

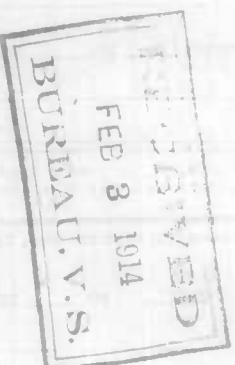
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

March 4

March 4<sup>th</sup>

1862

## 7 AGE

57

5-1

yrs.

9

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Cysterman

(b) General nature of industry, business, or establishment in which employed (or employer)

Crafter

## 9 BIRTHPLACE

(State or country)

Germany

## PARENTS

## 10 NAME OF FATHER

M. K. Kusev

11 BIRTHPLACE OF FATHER  
(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Louise E. Kusev

13 BIRTHPLACE OF MOTHER  
(State or country)

Germany

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Virginia Steele

(Address)

Deale's Island Md

## 15

Filed

Jan 5<sup>th</sup> 1914

Geo. B. Horner

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

368

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 4<sup>th</sup>, 1914

## 17

I HEREBY CERTIFY, That I attended deceased from

Sept 15<sup>th</sup> 1913 to Jan 4<sup>th</sup>, 1914that I last saw him alive on Jan 4<sup>th</sup>, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Valvular heart lesion

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Jan 5<sup>th</sup>, 1914 (Address) Deale's Island

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Deale's Island Md Jan 5<sup>th</sup>, 1914

## 20 UNDERTAKER

## ADDRESS

Geo. B. Horner Deale's Island Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

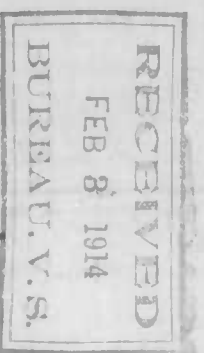
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

844

County SomersetSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 260Village or City Champt. Md. (No. 91)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Ruth Elizabeth Wallace

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Child  
(Write the word)

6 DATE OF BIRTH February 26, 1913  
(Month) (Day) (Year)

7 AGE 10 yrs. 27 mos. 27 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Champt. Md.

## PARENTS

## 10 NAME OF FATHER

Levin S Wallace

## 11 BIRTHPLACE OF FATHER

(State or country)

Oriole Md

## 12 MAIDEN NAME OF MOTHER

Martha E. Breames

## 13 BIRTHPLACE OF MOTHER

(State or country)

Dorchester Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Levin S. Wallace

(Address)

Oriole Md.

## 15

Filed 1/22, 1914J. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 22, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1914 to Jan 22, 1914,

that I last saw her alive on Jan 22, 1914

and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 6 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

John E. Ruby

M. D.

Jan 22, 1914 (Address) Oriole Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Oriole1/22, 1914

## 20 UNDERTAKER

## ADDRESS

J. E. WilberThomas Quinn

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

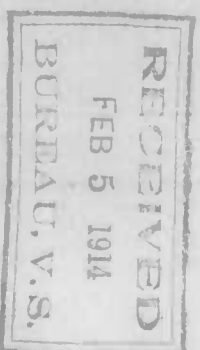
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housekeeper*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Somerset</u>		845		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Deals Island</u> (No. <u>103</u> )		St.; Ward		Registration Dist. No. <u>268</u>	
2 FULL NAME <u>Louise E. Webster</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)			
6 DATE OF BIRTH <u>May 8, 1832</u> (Month) (Day) (Year)					
7 AGE <u>81</u> yrs. <u>7</u> mos. <u>25</u> ds. If LESS than 1 day.....hrs. OR.....min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Noah Kelly</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Daniel</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Korea Webster</u> (Address) <u>Deals Island</u>					
15 Filled <u>Jan 4, 1914</u> <u>Geo B Horner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 2, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 30, 1913</u> , to <u>Jan 2, 1914</u> , that I last saw him alive on <u>Jan 2, 1914</u> , and that death occurred on the date stated above, at <u>6 P. m.</u> , The CAUSE OF DEATH* was as follows:					
<u>Gastritis, Acute</u> <u>18</u> (Duration) yrs. mos. <u>5</u> ds. Contributory <u>Senile Debility</u> Secondary (Signed) <u>E. J. Simpson</u> , M. D. <u>MAR 26 1914</u> (Address) <u>CHANGE MD</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Deals Island</u>				DATE OF BURIAL <u>Jan 4th, 1914</u>	
20 UNDERTAKER <u>Leonard G. Webster</u>				ADDRESS <u>Deals Island</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Cars should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

RECEIVED  
FEB 8 1914  
BUREAU, U. S. S.

Can't for sig. in correct form

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc., State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

Village or City Marion, Ind. (No. 91 St.; Ward)

2 FULL NAME Oliver Wallace Whittington

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 265

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH about 1875  
(Month) (Day) (Year)

7 AGE 39 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Whittington

(Address) Marion, Ind.

15 Filed Jan 26, 1914 Dr. Gallins  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Jan 1, 1914, to Jan 24, 1914, that I last saw him alive on Jan 22, 1914, and that death occurred on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(Duration) — yrs. — mos. 24 ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) W. J. Barkley, M. D.  
Jan 24, 1914. (Address) 309 W. 2nd Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Near Marion Sta DATE OF BURIAL Jan 25, 1914

20 UNDERTAKER A. J. Adams ADDRESS Griffith

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 3 1914

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BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County SouthernVillage or City Princess Anne (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Wilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept, 1862  
(Month) (Day) (Year)

7 AGE 53 yrs. — mos. — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Stammer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

PARENTS  
10 NAME OF FATHER Lewis Wilson  
11 BIRTHPLACE OF FATHER (State or country) Ind.  
12 MAIDEN NAME OF MOTHER Mary Leather  
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Wilson(Address) Princess Anne, Ind.

15 Filed Jan 28, 1914 J. J. Smith  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1913, to Nov 28, 1913, that I last saw him alive on Nov 28, 1913.

and that death occurred on the date stated above, at 5:20 a.m.  
The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary(Duration) \_\_\_\_\_ yrs. 2 mos. \_\_\_\_\_ ds.

(Signed) John J. Smith, M. D.  
1/28, 1914 (Address) Princess Anne, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At Home 1/29, 1914

20 UNDERTAKER

ADDRESS

James J. Smith Princess Anne, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

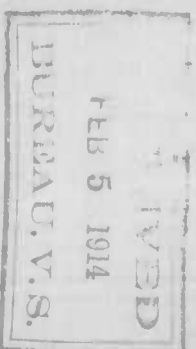
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Summit</u> 848		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Wt Vernon</u> (No. <u>109</u> )		Registration Dist. No. <u>263</u>	
2 FULL NAME <u>William A Wilson</u>		St: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>Dec 6</u> , 18 <u>50</u> (Month) (Day) (Year)			
7 AGE <u>63</u> yrs. <u>1</u> mos. <u>19</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>19</u> min. ? if LESS than 1 day, hrs. min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Summit Co.</u>			
PARENTS	10 NAME OF FATHER <u>Levin Wilson</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>		
	12 MAIDEN NAME OF MOTHER <u>Rachel Bradley</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. A. Wilson Jr</u> (Address) <u>Summit Co. Ind</u>			
15 Filed <u>Jan 25</u> , 191 <u>4</u> <u>Arthur M. Loebe</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 25</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1</u> , 191 <u>4</u> , to <u>Jan 25</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 25</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5:30 A. m.</u> The CAUSE OF DEATH* was as follows: <u>Obstruction of the ascending colon</u>			
(Duration) _____ yrs. _____ mos. _____ ds.			
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>W. A. Wilson Jr</u> , M. D. <u>Jan 25</u> , 191 <u>4</u> . (Address) <u>Summit Co. Ind</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Wt Vernon Ind</u>		DATE OF BURIAL <u>Jan 26</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Orschell Bros</u>		ADDRESS <u>Summit Co. Ind</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

